

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (POC)		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 39C0001272	(X2) MULTIPLE CONSTRUCTION: A. BLDG: <u>00</u> B. WING: _____		(X3) DATE SURVEY COMPLETED: 12/06/2022
NAME OF PROVIDER OR SUPPLIER: TREVOSE SPECIALTY CARE SURGICAL CENTER, LLC STATE LICENSE NUMBER: 22411501			STREET ADDRESS, CITY, STATE, ZIP CODE: 4979 OLD STREET ROAD Suite C TREVOSE, PA 19053		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE	(X5) COMPLETE DATE	
Q 0000	<p>INITIAL COMMENT</p> <p>This report is the result of a full Medicare recertification survey conducted on December 6, 2022, at Trevoze Specialty Care Surgical Center. It was determined the facility was in compliance with the requirements of 42 CFR, Title 42, Part 416 - Conditions for Coverage for Ambulatory Surgical Centers.</p> <p>It was also determined the facility was in compliance with 42 CFR, Title 42, Part 416 - Conditions for Coverage for Ambulatory Surgical Centers at 416.51(c)(1)-(3)(i)-(x) COVID-19 Vaccination of Facility Staff.</p>	Q 0000			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE:

(X6) DATE:

Any deficiency statement ending with an asterisk (*) denotes a deficiency which may be excused from correction providing it is determined that other safeguards provide sufficient protection to the patients. The findings stated above are disclosable whether or not a plan of correction is provided. The findings are disclosable within 14 days after such information is made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

This form is a printed electronic version of the CMS 2567L. It contains all the information found on the standard document in much the same form. This electronic form once printed and signed by the facility administrator and appropriately posted will satisfy the CMS requirement to post survey information found on the CMS 2567L.

[illegible]

(X6) DATE:



Certified End Page

TREVOSE SPECIALTY CARE SURGICAL CENTER, LLC

STATE LICENSE NUMBER: 22411501

SURVEY EXIT DATE: 12/06/2022

**I Certify This Document to be a True and Correct Statement of Deficiencies and
Approved Facility Plan of Correction for the Above-Identified Facility Survey**

A handwritten signature in black ink that reads "Jeane Parisi".

Jeane Parisi
Deputy Secretary for Quality Assurance

A handwritten signature in black ink that reads "Debra L. Bogen MD".

Debra L. Bogen, MD, FAAP
Acting Secretary of Health



THIS IS A CERTIFICATION PAGE

PLEASE DO NOT DETACH

THIS PAGE IS NOW PART OF THIS SURVEY